

# **FIRST-TIME MOTHERS' CHOICE OF BIRTHPLACE: INFLUENCING FACTORS, EXPECTATIONS OF THE MIDWIFE'S ROLE AND PERCEIVED SAFETY**

## **ABSTRACT**

**Aim.** To explore first-time pregnant women's expectations and factors influencing their choice of birthplace.

**Background.** Although outcomes and advantages for low-risk childbearing women giving birth in midwifery-led units and home compared with obstetric units have been investigated previously, there is little information on the factors that influence women's choice of place of birth.

**Design.** A qualitative Straussian grounded theory methodology was adopted. Fourteen women expecting their first baby were recruited from three large National Health Service organisations that provided maternity services free at the point of care. The three organisations offered the following birthplace options: home, freestanding midwifery unit and obstetric unit. Ethical approvals were obtained and informed consent was gained from each participant.

**Methods.** Data collection was undertaken in 2013-2014. One tape-recorded face-to-face semi-structured interview was conducted with each woman in the third trimester of pregnancy.

**Findings.** Findings are presented as three main themes: a) influencing factors on the choice of birthplace; b) expectations on the midwife's 'being' and 'doing' roles; c) perceptions of safety.

**Conclusion.** Midwives should consider each woman's expectations and approach to birth beyond the planned birthplace, as these are often influenced by the intersection of various influencing factors. Several birthplace options should be made available to women in each maternity service and the alternatives should be shared with women by healthcare professionals during pregnancy to allow an informed choice. Virtual tours or visits to the birth units could also be offered to women to help them familiarise with the chosen setting.

**Keywords:** midwifery; women's health; childbearing; choice; birthplace; place of birth; obstetric unit; homebirth; freestanding midwifery unit; pregnancy.

## **SUMMARY STATEMENT**

### **Why is this research needed?**

- Although outcomes and advantages for women giving birth in different settings are demonstrated, there is little information on the factors that influence women's choice of birthplace.
- By understanding factors influencing women's choice of birthplace, healthcare professionals may be better able to facilitate informed choice; this is highlighted as a key factor in moving maternity provision forward.

### **What are the key findings?**

- This paper contributes novel evidence on women's expectations around choice of birthplace, increasing understanding of the factors that are important to them when choosing a preferred birth setting, including proximity; normality of childbirth; environment; model of care; TV programmes; recommendations from family and friends.
- Participants specified that the midwife's role should include both spheres of 'being' and 'doing'. Some participants planning to give birth in an obstetric unit confined the midwife's role to 'doing checks'.
- Women's perceptions of birthplace safety varied, including having medical backup available in obstetric units, one-to-one dedicated midwifery care in freestanding midwifery units and complete trust in a known midwife for homebirth.

### **How should the findings be used to influence policy / practice / research / education?**

- Women's expectations and approach to birth should be considered beyond the chosen planned birthplace, as these are often influenced by the intersection of various influencing factors.
- As geographical location could sometimes limit women's choice of birthplace, several birthplace options should be made available in each maternity service.
- The alternatives available and their characteristics should be shared with women by healthcare professionals during pregnancy, including visits to birth units to allow informed choice.

## INTRODUCTION

The place where women give birth has substantially changed over the past century in developed countries (Kirkham, 2003). At the beginning of the last century the greatest number of births occurred at home; during the 1960s birth was mainly seen as a surgical procedure and by the end of the century almost all *deliveries* occurred in hospital (Bonney, 1919; DeVries et al., 2001). In the early 1980s, demands for more choice in childbirth were growing in England, supported by a network of maternity consumer groups (Declercq, 1998). The *Changing Childbirth: Report of the Expert Maternity Group* (Cumberlege et al., 1993) encouraged significant changes in maternity care, including the aim of providing women with real choice of place of birth. The recent *National Maternity Review* (Cumberlege et al., 2016) recognises that although improvements have been made since the 1990s, the recommendations from *Changing Childbirth* (Cumberlege et al., 1993) have not been fully realised. Four places of birth are currently offered in England: obstetric units (OUs), alongside midwifery units (AMUs), freestanding midwifery units (FMUs) and home (Redshaw et al., 2011). Despite the range of possible birthplaces, 87% of births took place in OUs in 2012 (NAO, 2013) and considerably fewer women gave birth in AMUs (9%), FMUs (2%) (Redshaw et al., 2011) or at home (2%) (NAO, 2013).

## Background

It is largely acknowledged that non-traditional places of birth (home, FMUs and AMUs) present advantages for low-risk women, when compared with OUs. In particular, research brings to light greater maternal satisfaction (Birthrights, 2013; Dahlen et al., 2010; Overgaard et al., 2012; Waldenstrom and Nilsson, 1993); provision of woman-centred care (Overgaard et al., 2012); lower costs for maternity care (Stine et al., 2012; Toohill et al., 2012); better

maternal/neonatal outcomes and lower use of medical procedures without associated risks (Hodnett et al., 2010; Sandall et al., 2013; Sutcliffe et al., 2012).

Walsh and Downe (2004) encourage the provision of midwife-led care for low-risk women, debating whether there is an increased risk of morbidity for mothers who are eligible for such units but who labour and birth in obstetric units. In fact, despite choice of birthplace being considered important by women, they often assume birth takes place in a medicalised environment and feel safer and more at ease with birth occurring in a OU (Houghton et al., 2008). Women planning hospital birth may conceptualise birth as ‘medically risky’, with no ‘concerns about overuse of birth interventions’, which are instead often ‘considered an essential form of rescue from the uncertainties of birth’ (Coxon et al., 2014: 51).

The *National Maternity Review: Better Births* from NHS England (Cumberlege et al., 2016) and the *National Service Framework for Children, Young People and Maternity Services* (DH, 2004) support the fact that childbearing women should be able to choose how and where they give birth. However, from a national survey of 10,000 women giving birth in England, the reality of care seems somewhat different (Redshaw and Heikkila, 2010). Despite the perception that the quality of care during labour was high, 80% of women were not aware of all the available options in regard to places of birth. The question is whether women would have chosen alternative settings if they were fully informed about all the possibilities.

Although outcomes and advantages for low-risk childbearing women giving birth in FMUs, AMUs and home when compared with OUs have been demonstrated, there is little information on the factors that influence women’s choice of birthplace and whether women’s expectations of the caregiver, labour and birth differ by where they choose to give birth. These appear to be highly relevant topics with significant implications for practice in the light of contemporary national and international debates and for service delivery to support the policy context (Coxon

et al., 2012; Coxon et al., 2014; Coxon et al., 2015; Cumberlege et al., 2016; Grigg et al., 2014; Murray-Davis et al., 2014; Overgaard et al., 2012; Redshaw et al., 2011). By understanding facilitators and barriers to women with straightforward pregnancies booking a FMU/AMU/home birth, healthcare professionals may be better able to address issues around birthplace choice; this has been highlighted as a key factor in moving maternity provision forward (Cumberlege et al., 2016).

## **THE STUDY**

### **Aim**

This research aimed at exploring first-time pregnant women's expectations and factors influencing their choice of birthplace. The research questions were: What are the factors influencing a first-time pregnant woman's choice of birthplace? What are women's expectations of the midwife's role in different birthplaces? What do women perceive as safe in regard to different birthplaces?

### **Design**

A qualitative Straussian grounded theory methodology was adopted. The philosophical underpinnings of this research combined constructivist ontology with interpretivist epistemology. The findings presented here derive from a larger grounded theory study exploring first-time mothers' expectations and experiences of a good midwife during childbirth in different places of birth (Borrelli, 2014; Borrelli et al., 2016). Findings focussing on choice of birthplace are presented in this paper. The full methodological details are reported in Borrelli et al. (2016).



## **Sample**

The sampling strategy was purposive and the sample size was determined by data saturation. Fourteen women expecting their first baby were recruited from three large National Health Service organisations that provided maternity services free at the point of care. The three organisations offered the following birthplace options: home, freestanding midwifery unit (FMU) and obstetric unit (OU). The inclusion criteria included women in good general health expecting their first baby, with low risk pregnancy (single fetus) and anticipating a normal birth. Recruitment took place between June and November 2013. Women were approached by community midwives providing antenatal care during the third trimester of pregnancy. Women who wanted to participate completed a contact details form; the principal investigator telephoned potential participants to explain the study and to arrange a suitable time to gain informed consent and carry out the interview.

## **Data collection**

Data collection was undertaken from June 2013 - January 2014. A tape-recorded face-to-face semi-structured interview was conducted for each woman in the third trimester of pregnancy, making a total of fourteen interviews. Thirteen interviews were undertaken at the women's own homes; one interview was done in a café at the participant's request. The semi-structured interviews included open-ended questions to enable the balance between focusing on significant areas and encourage participants to share their perspectives (Rees, 2011; Rose, 1994). Initial topics were developed from the literature and agreed by the research team; the preliminary data analysis subsequently guided the continuous adjustment of the interview guide according to what was revealed as meaningful to participants. Key topics explored in regard to birthplace were: decision-making process; factors influencing choice of birthplace;

expectations of the midwife's role in different birthplaces; perception of safety and control. The average duration of the interviews was 30 minutes. Each interview was labelled with a reference code indicating a pseudonym and the acronym of planned birthplace.

### **Ethical considerations**

Ethical approvals were obtained from Multicentre Research Ethics Committee and the respective Research and Development departments before entering the research sites. Written consents were obtained from participants, who were free to decline participation or to withdraw at any time. They were offered the option of receiving a summary of the findings on conclusion of the study. Pseudonyms are used to protect confidentiality.

### **Data analysis**

Each interview was listened to, transcribed and analysed before undertaking the next fieldwork. The data were collected, coded and analysed by SB, under DW and HS supervision, including regular discussion of emerging themes. Data analysis was performed manually and memos were used as part of grounded theory analytical technique (Strauss and Corbin, 1998). Data analysis followed the phases of open coding; axial coding; selective coding; theory development (Strauss and Corbin, 1998: 58). More details on the iterative analytical process are available in AUTHORS BLINDED (2016). Consensus of final interpretation of themes was reached.

### **Trustworthiness and rigour**

Trustworthiness and rigour of this grounded theory study were guaranteed by four central criteria: fitness, understanding, generality and control (Glaser and Strauss, 1967: 237). The principal investigator (SB) is a midwife by background and was undertaking a PhD course at the time of the study. Co-authors (DW and HS) are midwives, experienced researchers and SB's academic supervisors. Although 'midwifery lenses' were inevitably used in collecting, analysing and interpreting findings, openness to data and theoretical sensitivity were considered throughout the study, trying to limit pre-conceived thoughts. In regard to the literature, having some familiarity with publications around the topic sensitised the authors to what was happening with the phenomenon under study (Strauss and Corbin, 1998). However, previous knowledge on existing evidence did not preclude the iterative inductive-deductive approach at the heart of grounded theory. Reflexivity was used to minimise prior knowledge misleading perception of data and to stimulate questions during data collection and analysis. Different incidents and disconfirming data were constantly compared in the same and different interviews. When building themes, the authors reflected on the entire stories recounted by women rather than considering individual quotes 'detached' from expectations and experiences as a whole; in this way, the interview's components were put into context and grounded in the whole data.

## **FINDINGS**

The study participants ranged in age from nineteen to forty-three years, with an average age of twenty-nine years. Women were between 36-40 weeks of pregnancy, with an average gestational age of 38 weeks. Five of the recruited women were planning to give birth at an OU, seven at an FMU and two at home (of whom one was undecided between home and the FMU).

Findings are presented as three themes: **a)** influencing factors on the choice of birthplace; **b)** expectations on the midwife's 'being' and 'doing' roles; **c)** perceptions of safety.

### **Influencing factors on the choice of birthplace**

The participants referred to the following influencing factors in their choice of birthplace: geographical proximity; normality of childbirth; environment; model of care; TV programmes; recommendations from family and friends.

One of the main reasons provided by the women for choosing a specific place of birth was its geographical proximity, not for the couple alone but also for family members and friends visiting after birth. Participants stated they would prefer to give birth in a local and familiar setting and did not want to worry about travelling at labour onset:

It's just closer to where I live for my family. [...] I don't really want to be worrying about travel and birth. (Alice-OU)

I wanted to be able to have my baby somewhere I feel familiar, somewhere that's close to friends and family and then just come home! (Emma-FMU)

Some women were planning to give birth in a FMU because of their beliefs in the normality of childbirth. Having had a straightforward pregnancy so far, they did not see why they should give birth in a medicalised environment. Moreover, they supposed that a midwifery-led unit may give them the natural birth they wanted:

I haven't necessarily got any problems which are stopping me from going so I thought 'why not?' (Laura-FMU)

I don't need to be, touch wood, in a hospital [...] because this is a low risk pregnancy.

[...] I've chosen the birth centre because I am more likely to have the natural process that

I want. (Jayne-FMU)

Independently from the birthplace, the interviewees expressed their desire of giving birth in a nice, friendly, clean and tidy environment. The women planning to give birth in a FMU talked about a home-like, quiet and relaxed setting. The search for a labour room with a birthing pool played an important role in some cases. Some of the participants felt more confident after having physically or virtually seen the place of birth:

I wanted somewhere that's a little bit more comfortable and more familiar, which is why

I've gone for the birth centre. [...] Every time I go there it feels quite familiar. [...] a bit

more relaxed. (Emma-FMU)

I've looked on the internet as well, they had a video that shows you about the hospital

and gives you information about it which I really liked. (Sophia-OU)

Several participants made an apparent distinction between the midwife, the birthplace and the model of care. The choice of the women planning to give birth at home or in a FMU seemed to be more related to the general atmosphere and environment of the birth setting and to the model of care rather than the midwife. Women recognised that the time the midwife would be able to dedicate to them was related to contingent factors such as the unit size, the ward busyness and shortages of staff. The presence or absence of models of care allowing one-to-one individualised woman-centred care and paying attention to natural childbirth were considered as one of the main differences between FMUs and OUs:

It's a midwife-led unit, a quiet unit and a small unit and they're not dealing with the volume of women that they do at the hospital. So then you've got that attention, you've got that one midwife that is looking after you. (Jayne-FMU)

Well, I don't know if better than in the hospital but I know that their approach to natural birth is... they believe in no intervention. (Louise-HOME/FMU)

Having met the team of midwives during pregnancy and the midwives remaining available to visit them at home in early labour also played an essential role in the choice of FMU as birthplace:

They come out to you instead that you go into them and then being sent away. (Laura-FMU)

They send you the midwife to see you when you go into labour or you have any problems, whereas if you're booked at the hospital you have to go all the way there for any kind of assessment [...] It's more likely to be somebody that I know or have seen around. (Kate-FMU)

Watching childbirth-related TV programmes seemed to offer a negative picture of birth and to influence the women's choices of the place of birth in several and different ways, bringing up divergent choices among the participants of this study. For instance, some women were scared about how 'things could go wrong so quickly' and therefore chose to give birth in an OU to have a medical backup immediately available:

I suppose it was watching that one programme that is why we're going to the hospital. Realising how quickly it can go wrong and needing that medical back up at that speed is why we are going to the hospital. (Michelle-OU)

Some women planning to give birth at home or in a FMU reported that the TV programmes showed a negative portrayal of hospital birth and this was exactly what they did not want for their labour and birth. Although she was still planning to give birth in a FMU, the TV programmes influenced Emma against a home birth:

I guess that's kind of my understanding of what the hospital ward would be like if I was there which is another reason why I don't want to do it. [...] I just think it looks like a horror story. [...] I categorically do not want that experience. (Emily-HOME)

I think some of them [TV programmes] are what scared me off having a homebirth. (Emma-FMU)

Some women referred to recommendations from family and friends based on personal experiences as a quite significant influence in considering birthplace options:

A couple of my friends have already had their babies at the birth centre and all of them have had a good experience whereas some other people [...] have been to other hospitals. It's been a variety of comments and feedbacks. (Melissa-FMU)

### **Expectations on the midwife's 'being' and 'doing' roles**

Whether the women were planning to give birth at home, in a FMU or OU, they thought that there was no difference between midwives practising in different settings; therefore, their idea of a good midwife seemed not to influence their choice of birthplace. Participants reported that they did not choose where to give birth in relation to seeking specific qualities in the midwife during childbirth. The women assumed that midwives are 'good anyway' and would not 'get very far if they are not doing their job properly' (Emma-FMU). In regard to this, interviewees'

general perceptions were that most midwives are good professionals, approachable and friendly, irrespective of their work base. In particular, participants raised the point that the midwives' ability to practise competently and safely is guaranteed by academic and NHS standards. The women also reported their positive experiences with midwives so far during pregnancy, thus they wondered why they should have a negative encounter with the midwife at the time of labour:

I guess if you have been assigned a midwife then you assume automatically that they would have been trained at certain standards [...] that the person is properly trained and qualified. (Emily-HOME)

You expect them to be bubbly, friendly. Especially because I haven't had a bad experience as of yet. (Sophia-OU)

When asked to describe the midwife's role, the importance of a midwife's ability to balance the spheres of being and doing was reported by several women, regardless the planned birthplace. The participants specified that the midwife's role should include the following spheres of skills: being there (providing moral support); doing nothing (staying in the background and doing nothing until needed); delivering the baby safely; doing checks (having the knowledge to understand when/how to monitor and intervene):

I think being there, stepping in, telling me what to do and encouraging you [...] not taking over but taking over when they have to. [...] being in the background-ish but keeping an eye and then step in. (Laura-FMU)

Just that they'll be there for you and obviously, deliver the baby safely. Then [...] if they're worried or anything they'll know when to intervene. (Alice-OU)



I imagine that the midwife will just be there to support me really and to check on me, check my vital signs [...] and the baby's heartbeat. Be there as a support without any medical intervention but being aware of what's happening. Looking after me medically without intervening. (Jayne-FMU)

Sophia recognised 'being there' as the main role of the midwife, that should constantly guide, reassure and support the labouring woman:

I want the midwife there constantly guiding me through what's going to be happening next so then I know what's coming so I can plan myself. (Sophia-OU)

Concerning 'doing nothing', Louise emphasised the importance of receiving moral support rather than checks and interventions from the midwife:

It's more like the moral support for them to be there for me other than doing checks.  
(Louise-HOME/FMU)

'Delivering the baby' was identified by some women planning to give birth in an OU as a midwife's job, rather than considering themselves as fully responsible for and capable of giving birth:

I just know that they're there to deliver your baby as safely as they can. (Alice-OU)

Just get her out as quickly as possible. (Mary-OU)

Some participants planning to give birth in an OU confined the midwife's role to the area of 'doing checks'. In particular, the interviewees argued that the midwife should monitor the woman and the baby, watch over the progression of labour and do the necessary examinations. These women expected the midwife to take control over the situation and tell them what to do if needed, delegating decisions to the professional:

Monitoring me, making sure that as a whole process is all going according to some sort of plan [...]. Making sure it's progressing and taking control when it is not. (Michelle-OU)

### **Perceptions of safety**

The women's perceptions of safety of birthplaces varied according to their planned place of birth. Several participants reported that their chosen birthplace was an OU because they felt that being surrounded by a medical environment was a safer option than giving birth in a midwifery-led unit or at home. Therefore, to them safety meant having immediate access to medical backup. However, the women argued for medical support to be external to their childbearing event and for obstetricians or other professionals to intervene only in the case of deviation from normality:

Not being a medical process but having that medical support immediately around you.

It's like the skin of an orange. The orange is 'I'm giving birth', the skin of the orange is 'and I've got everything here if anything goes wrong'. (Michelle-OU)

I think you do feel safer in a hospital. [...] Seem to have everything there that you need.  
(Hannah-OU)

Interviewees planning to give birth in a FMU felt they would be safe because they would be the centre of attention in the context of a one-to-one, individualised and woman-centred model of care. This made them feel relaxed about the fact that if anything happened the midwife would notice it straight away. In this case, the safety perceived by the women was associated with the provision of one-to-one, attentive individualised care:

I feel like their attention is not taken elsewhere. I know that if anything happen they'd see it straight away. (Emma-FMU)

I think I trust the midwife more than doctors. The midwife has got more an idea of what is going on. (Rebecca-FMU)

The participant that chose home as her place of birth, placed her complete trust in the midwife's expertise and ability to deliver her baby safely and in the way she wanted unless medical intervention was needed. The woman-midwife relationship established during pregnancy played an important role in this case. As opposed to the two quotes from Michelle-OU and Hannah-OU, in the following the two concepts of safety and medical support/environment seemed to diverge, with safety being entirely related to the midwife's competence in providing the best care for the woman and her baby during labour and birth:

She knows exactly what I want [...] and she'll try her best to be sure this baby is delivered safely and in the kind of the way that I want unless medical intervention is needed.  
(Emily-HOME)

## **DISCUSSION**

First-time mothers interviewed for this study had a clear idea of where they wanted to give birth. Overall, they referred to birthplace decision-making as a personal choice rather than as a decision made together with the partner or the family. Recent research established that women usually perceive themselves as the main birthplace decision-makers (Grigg et al., 2014), with choices made generally before pregnancy or during the first trimester (Murray-Davis et al., 2014). The reasons behind the choice of place of birth emerged quite clearly in this study. Some

general motives were shared across different birthplaces, while specific reasons were referred to by women planning to birth either in an OU, in a FMU or at home.

Regardless of the planned birthplace, the women's decision making on the place of birth was generally influenced by proximity to home, friendliness, cleanliness and tidiness of the birth setting, often referring to recommendations from family and friends. Proximity was highlighted as one of the main driving factors for choosing OUs, suggesting that the variable geographical location, distribution and accessibility of midwife-led units across the country can have a significant impact on women's choice of place of birth.

Media appear to influence how women engage with childbirth, mainly by dramatically portraying medicalisation of childbirth and often omitting normal birth (Luce et al., 2016). In the present study, watching TV programmes seemed to influence women's choices in several ways, including choosing an OU, a FMU or home as place of birth. Women that mentioned TV programmes referred to them as providing a negative picture of birth and caregivers. In the current technological era, the power that media and the internet may have on childbearing women should not be underestimated. The media have contradictory impacts for women; in fact, although they are often reassured and helped through decision-making, distress might come from watching and listening to negative stories, as reported by some participants of this study (Morris and McInerney, 2010).

Grigg et al. (2014) and Murray-Davis et al. (2014) recently found that books and research are generally seen as important sources of information by women when shaping their ideas about a preferred birthplace. Women's expectations of a good midwife were not reported as an influencing factor on the choice of the place of birth, as the interviewees mainly defined all midwives as good by default and independently from the work setting. The participants'

perceptions on the differences between birthplaces were rather related to the environment, atmosphere and model of care.

Women planning to give birth in a FMU expressed their preference for a home-like, quiet and relaxed setting which would promote normal childbirth and one-to-one individualised woman-centred care. Similarly, a woman who preferred homebirth wanted to avoid interventions and felt most relaxed in her familiar setting. Walsh (2006: 228) argued that ‘intuitive nesting-related behaviours’ appeared to be evoked by women in their evaluation of the appropriateness of the place of birth. The environmental atmosphere and avoidance of unnecessary medical interference are identified as influencing factors among women planning to birth in a FMU or at home (Grigg et al., 2014; Murray-Davis et al., 2014).

Although safety of birthplaces and related benefits/risks have been largely debated in the last decade (Hodnett et al., 2010; Hollowell et al., 2011; Janssen et al., 2009), there is a dearth of information on what safety of place of birth means to childbearing women. Although all the participants of this study declared their preference for a birth as natural as possible with no medical interventions, they reported various perceptions of safety of childbirth in different places of birth, providing a new insight in this area. Women generally believed that their planned place of birth was the right and safer place for them. Women planning an OU birth conceived safety as having medical backup readily available; however, they still expected to receive midwifery care and make use of consultant care only if necessary. Similarly, Houghton et al. (2008) claimed that women often assume birth would take place in the hospital environment, feel more at ease when birth occurs in an OU and perceive it to be a safer environment. Other evidence suggests that accessing a specialist facility and having access to pain medication were identified as the most important factor by women planning a hospital birth (Grigg et al., 2014; Murray-Davis et al., 2014). For women planning a FMU birth, safety

meant receiving one-to-one, individualised and woman-centred care. In the context of homebirth, safety was considered as having complete trust in the midwife's expertise and ability to deliver the baby safely and in the way the woman wants, as if the competence and presence of the midwife would create a 'safe haven' at the woman's own home, characterised by the midwife's 'safe hands', 'caring approach' and 'peaceful presence' (Sjöblom et al., 2014: 100). Whatever the planned place of birth, Moberg (2015) argues that 'the mother needs to feel safe and protected and so the birthing place must be perceived as safe and welcoming'.

Authors have often associated women that choose FMUs and home birth with more non-technological approaches to childbirth (Van Der Hulst et al., 2004) and greater desired levels of choice and responsibility in the childbirth experience (Cohen, 1981; Coxon et al., 2014; Dahlen et al., 2010; Fullerton, 1982; Hodnett et al., 2010; Neuhaus et al., 2002) when compared with women planning to birth in hospital settings. Viisainen (2001: 1109) suggested that 'two competing cultural models of childbirth, the biomedical/technocratic model and natural/holistic model, mediate women's choices and preferences for the place and caregiver in childbirth'. However, the findings of this study challenge this tendency as even when choosing to birth in an OU, women still preferred to have a natural birth and sought to be in control of their birth experience. Moreover, the women's overall perception of childbirth as a natural process and the discontent reported following medicalised birth calls into question the idea that medical technology in childbirth seems to be frequently accepted as the norm (Johanson et al., 2002).

## **LIMITATIONS**

This research was undertaken in two regions in England and three NHS maternity care services supporting OUs, FMUs and home as birthplaces. Due to the low numbers of first-time mothers planning a homebirth, the researcher recruited a limited number of these participants. Women

from minority ethnic groups and those with an unstraightforward/complicated pregnancy were not enrolled as they would be automatically referred to an OU, with no other options on where to give birth. Therefore the applicability of the findings to these groups is limited. Although this is a small qualitative study and its findings cannot be generalised, the findings raise implications for practice that can be applied to similar contexts nationally and internationally.

## **CONCLUSION**

This paper contributes novel evidence on women's expectations around choice of birthplace, increasing understanding of the factors that are important to them when choosing a preferred birth setting. The findings of the study highlighted that each woman's expectations and approach to birth should be considered beyond the chosen planned birthplace, as these are often influenced by the intersection of various influencing factors. As geographical location could sometimes limit women's choice of birthplace, research findings lead us to recommend that several birthplace options should be made available in each maternity service. The alternatives available and their characteristics should be shared with women by healthcare professionals during pregnancy (e.g. at antenatal appointments and groups) to allow an informed choice. This is supported by the results of a systematic review from Henshall et al. (2016: 53), who identify the need for a 'pragmatic, understandable place of birth dialogue containing standard content to ensure midwives provide low risk women with adequate information about their place of birth options'. Visits to the birth units could also be offered to women to help them familiarise with the chosen setting. During midwifery education, students should have a meaningful exposure to women labouring in different birth settings, also experiencing intrapartum transfers and change of planned birthplace during pregnancy.

Further research is needed to understand factors that are important to women when choosing their preferred birth setting, including participants with a variety of characteristics (e.g. from different countries including rural and urban areas; multiparas; young mothers; women that had to change their planned birthplace due to a high risk pregnancy). The views of women who are low risk but choose an OU as planned place of birth require attention. The influence of social media and TV programmes on women's perceptions of places of birth and perceived safety need exploration. The ways maternity services facilitate or restrict choice of birthplace should be also investigated.



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